Care Home
Home Health Care with Heart

APPLICATION FORM

CHOOSE A CARE SERVICE:

HOME CARE		ASSISTED LIVING		HOOGGELEGEN CARE UNIT	
CARE@HOME ARE UNIT		ASSISTED CARE APARTMENTS			

URGENCY OF APPLICATION:

WITHIN 24 HOURS		WITHIN 1 WEEK	
WITHIN 1 – 3 WEEKS		OTHER:	

GENERAL CLIENT INFORMATION:

MR/MRS/MS:					
NAME:		MARRIED		UNMARRIED	
		ID NUMBER: (supply prescription, please)			
SURNAME:		CHURCH AFFILIATION:			
BIRTHDAY:		AGE:			
HOME ADDRESS:		POSTAL ADDRESS:			
POSTAL CODE:					
TEL: (H)		(W)		(C)	
EMAIL ADDRESS:					

PERSON RESPONSIBLE ACCOUNT PAYMENT:

NAME:		PS. The client is responsible for paying the account, as indicated on the account statement.
SURNAME:		The client is responsible for submitting the claim to the medical aid.

DETAILS OF NEXT OF KIN/CONTACT PERSON:

RELATION:		HOME ADDRESS:	
NAME:			
SURNAME:			
TEL: (H)		POSTAL ADDRESS:	
(W)			
(C)			
EMAIL ADDRESS:		POSTAL CODE:	

MEDICAL INFORMATION:

DR. NAME:		TEL: (EMERGENCY)	
SURNAME:		(W)	
EMAIL ADDRESS:		(C)	

HOSPITAL OF CHOICE:			
MEDI CLINIC WORCESTER		WORCESTER HOSPITAL	
OTHER:			

MEDICAL AID:	
MEDICAL AID NUMBER:	

MEDICAL HISTORY:

OPERATIONS (last 5 years)?	YES		
	NO		
BONE FRACTURES/HISTORY OF BROKEN BONES?	YES		
	NO		
HISTORY OF FAMILY ILLNESSES?	YES		
	NO		
ANY SERIOUS ILLNESSES IN LAST 5 YEARS?	YES		
	NO		
CURRENT MEDICAL STATE?			
MEDICAL / HOME CARE NEEDED FOR YOUR CONDITION?	YES		
	NO		
MEDICAL TREATMENT IN CASE OF EMERGENCY?			
IF YOU HAVE A PARTICULAR MEDICAL CONDITION, KINDLY PROVIDE A COMPREHENSIVE DESCRIPTION. OUTLINE THE PRESCRIBED TREATMENT AS RECOMMENDED BY A SPECIALIST OR PHYSICIAN:			

PRESCRIPTION: Please send a scanned copy of prescription together with your application form.

ALLERGIES?	YES		NO			SMOKER?	YES		NO		
NUTRITION:	NORMAL		SPECIAL DIET		PEG TUBE		NASOGASTRIC TUBE		SUPPLEMENTS		IV NUTRIENTS	
REASON:												
HYDRATION:	DEHYDRATION		EDEMA		IVT							
REASON:												

OBSERVATION:	OXYGEN		BLOOD PRESSURE		PULSE		BREATHING	
REASON:								
PAIN CONTROL:	INTENSITY: PLEASE EXPRESS THE LEVEL ON A SCALE OF 1 TO 5, NONE/MINIMAL/MODERATE/CONSIDERABLE/SEVERE							
1		2		3		4		5	
LOCATION:								
REASON:								
MENTAL CONDITION:	ORIENTED		COMA		FORGETFUL		DEPRESSION	
DISORIENTED		SEMI COMA		ANXIOUS		APATHETIC		
NOTE:								
CONTINENCE:	BLADDER CONTROL		CONTROL OF GI TRACT					
NOTE:								
INCONTINENT:	URINE		BOWEL MOVEMENTS		NAPPIES		CATHETER	
REASON:								
SKIN/WOUND CARE:	INTACT		HEMATOMA		THINNING/RED		WOUND	
REASON:								
WOUND:	LOCATION:							
LENGTH:		WIDTH:		DEPTH:				
DISCHARGE:								
PERSONAL CARE: (washing/dressing/getting up, etc.)	Partially reliant on help with personal care.		Completely reliant on assistance for personal care					
NOTES:								
AIDS:	Please tick the appropriate boxes if aids are necessary for mobility, hearing etc.							
WALKING STICK		WALKING FRAME		CRUTCHES		WHEELCHAIR		
GLASSES		HEARING AID		ARTIFICIAL DENTISTRY		BED BOUND		
CURRENT REHABILITATION:				OTHER COMMENTS:				
RECOMMENDATION:								

NOTES:	

EXPECTATION OF CARE

EARLY MORNING:	TEA without rusks		TEA with rusks		COFFEE without rusks		COFFEE with rusks	
BED BATH:	FULL BED BATH		HALF BED BATH		SHAVE		WASH HAIR	
SHOWER		BATH		MORNING		EVENING		
BREAKFAST PREPARATION (Feeding/ and/or serving breakfast)								
SERVE TEA / COFFEE WITH REFRESHMENTS (+- 11 am and =- 4 pm)								
LUNCH PREPARATION (Feeding and/or serving lunch)								
PREPARATION OF DINNER (Feeding and/or serving dinner)								
PREFERRED- NECESSARY (Rest after lunch/Outdoor)								
CLIENT INCONTINENT:	USE NAPPIES			NORMAL TOILET HABITS				
ADMINISTER MEDICATION AS PRESCRIBED								
REGULERING OP PERMANENTE/PERIODIEKE BASIS VAN:	Fever, Blood pressure, Hemoglobin level, Regulation of oxygen administration							

REQUIRED CRISIS ACTION			
CALL DOCTOR / AMBULANCE		FIRST AID	
CONTACT PERSON, RELATIVES		CARE@HOME	

Through this, CARE@HOME offers unwavering commitment to each client, providing round-the-clock service for peace of mind and satisfaction.